The Global Fund to Fight AIDS, TB, and Malaria: Performance and Vision

A Report Prepared for the UK Department for International Development

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1. Introduction

1.1 The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) was established very quickly in 2001 in response to a widespread perception that a rapid scale-up in financing was critical in the fight against the three diseases. Since it began operations in January 2002, GFATM has made important progress. It has raised substantial funding and become the world's largest donor for TB and malaria. 70% of the programs reaching the two-year renewal stage are showing solid results. Rwanda, for example, has put over 4,000 people on ARV treatment, more than double its program target, and GFATM programs in aggregate have financed ARV treatment for 130,000 people to date.

1.2 Nevertheless, GFATM faces several significant challenges. Programs in some countries, such as Uganda, Kenya and others, are experiencing acute difficulties. The process of starting programs and disbursing funds has been slow in many countries. Certain GFATM procedures are adding to recipient burdens and fragmentation, and there are major challenges in integrating GFATM finances with existing mechanisms such as SWAps (sector-wide approaches).

1.3 By introducing some key changes, GFATM can become stronger and more effective. This year's renewal decisions for over 100 grants signal the end of GFATM's start-up phase, and provide the ideal time to revise its policies and procedures to help make it more successful and bring its promise to reality.

2. Purposes and mandate of the Global Fund

2.1 GFATM was created to raise substantial additional funds and direct them to effective HIV/AIDS, TB, and malaria programs. It was designed to fill financing gaps and help scale up programs for country-led national plans, implemented with support from other international partners. DFID has been closely involved in key decisions on GFATM's objectives and structure as a founding Board member and through participation in Board committees. GFATM's Board mandates it to operate on several key principles, including:

- support programs with strong national ownership,
- act as a financing instrument only, with a small administrative structure working in cooperation with other partners,
- provide funding based on performance,
- operate openly and transparently with broad participation.

2.2 GFATM was designed to complement but not duplicate the activities of other donors, governments and local agencies. It expands the reach of donors like DFID by providing additional financing and operating in far more countries (currently 127). Since GFATM has no in-country support staff and only provides financing, success in national programs depends crucially on GFATM's actions and those of its partners – governments, the private sector, NGOs, and other donors. These other partners must:

- design national strategies and specific programs and projects,
- build the financial, procurement, technical, and monitoring and evaluation systems necessary to carry out national programs,
- provide training and technical assistance (partially financed by GFATM).

2.3 GFATM was built on three key assumptions:

(1) financing was a major constraint to combating the diseases,

(2) existing multilateral agencies could neither attract substantial new funding nor engender the confidence that they could use the resources effectively, and

(3) other actors could provide complementary services relatively easily, so rapid scale-up and integration with other programs with a small agency was possible.

2.4 The first two assumptions still seem appropriate, but the third does not: institutional and capacity constraints, as well as financing gaps, limit the ability to scale up quickly. GFATM's structure, while innovative and promising, creates several issues and tensions:

- The mandate as solely a financing agent creates demands on partners to devote staff time, provide technical assistance (TA), and adapt their own systems to new national programs to an extent not fully appreciated at GFATM's founding. More explicit arrangements for supporting TA and other services may be required.
- GFATM's small staff (80 in 2004, expanding to 130) – all located in Geneva – responds to donor pressures to minimize costs but creates heavy staff burdens and difficulties in communication and follow-through. The small cadre of country portfolio mangers is of particular concern (18 in 2004, expanding to 48 in 2005). GFATM's staff is extremely small relative to other funding agencies (Annex 2).
- The large number of recipients requires differentiated procedures that have not yet been fully developed. ***A key challenge for GFATM is to integrate its processes where national systems work well, help redesign systems where they work poorly and risks are high, and establish new systems where none exist***. In some cases (but not all) GFATM's systems (e.g., Country Coordinating Mechanisms and Local Fund Agents) have made integration more difficult. Weaknesses in recipients' management capacity and financial systems also impede progress.
- The core principles of additionality and showing measurable results on three specific diseases lead to a vertical approach that creates difficulties in integrating with broader donor programs, especially budget support and SWAps.

2.5 GFATM's stakeholders naturally have a range of different expectations and concerns. The U.S. focuses on speed, costs and demonstrable results, is not concerned about harmonization and tends to favor vertical approaches. European donors place a high priority on harmonization, integration, and budget alignment. Civil society groups highlight participation and transparency, support the focus on thee diseases, and are wary of government domination and too much funding going through budgets. Many of these differences were not fully resolved at GFATM's founding and balancing them is at the heart of the challenges going forward.

Key Points:

- GFATM's structure, mandate, and focus on three diseases help focus its objectives and attract funds, but create difficulties in integrating with existing systems with different objectives, especially given its small secretariat and large number of client countries.
- GFATM's reliance on partners to play complementary roles has created unforeseen pressure on those agencies to devote resources and adjust their own systems.

3. Performance Measures

3.1 Because of its rapid start-up, GFATM had to design and introduce its systems while simultaneously operating its early grants. In 2004 the Board approved a performance measurement framework with four levels (see Annex 3 for details). Very few donors have such an extensive system, and fewer still make it public.

3.2 ***i) Institutional operations***, measuring resource mobilization, proposal processing time, disbursements, and costs. Quantitative indicators are augmented by focused studies, for example on Local Fund Agents (LFAs) or Country Coordinating Mechanisms (CCMs). This system is a major improvement but could be strengthened by better tracking disbursements from Principal Recipients (PRs) – often Government Ministries - to sub-recipients, and by measuring LFA assessment times.

ii) Grant performance, based on targets such as the number of people treated, commodities delivered, and staff trained (see Annex 4). Data are made public as grants reach their two-year renewal decision point. The set of indicators seem appropriate, subject to the usual difficulties of accurately measuring performance of any program. GFATM, WHO, UNAIDS, UNICEF, the World Bank, and several US agencies jointly developed a "Monitoring and Evaluation Toolkit" with common indicators for the three diseases. This system has improved dramatically during the last 18 months. Nevertheless, some key issues remain:

- GFATM's Technical Review Panel assesses targets for each grant, but it often does not have country contextual information, and there are concerns about its ability to judge systems issues.
- Quarterly reporting (rather than semi-annual) may be an unnecessary burden. In some cases, the GFATM has relaxed this requirement.
- Data may not be fully accurate, and LFAs may have limited verification ability.
- The feedback loops from the LFA reports to the CCMs, program implementers and other partners are often incomplete.
- GFATM's mandate to measure performance is harder in the context of basket funding or SWAps:
    - SWAps have objectives beyond the three diseases, and most do not incorporate such specific indicators.
    - Attribution of results to individual funding sources is difficult.
    - Measuring additionality of funding is harder in a SWAp context.

There are major tensions between GFATM's mandates to focus on the three diseases, measure performance, and show additionality while at the same time integrating and harmonizing with existing systems with different objectives. Balancing these tensions will require flexibility and commitment by both GFATM and SWAp partners. These problems are important for relatively few countries: less than 20 of GFATM's 127 countries have SWAps, and the others require different approaches. At a broader level, GFATM needs to have the depth and flexibility to use different approaches in different countries, while still being able to compare results across countries.

iii) System effects, measuring GFATM's impact on additionality, sustainability of responses to the diseases, and partnerships, including harmonization and the CCMs. These measurements systems are in an early stage after a broad consultative process in 2004. Data will be collected for a sample of pilot countries in 2005, and partners will be able to provide feedback as the process proceeds, particularly through the Monitoring and Evaluation Committee. There is a heavy emphasis on CCM performance, reflecting the strong concerns of some constituents. The harmonization measures appear to be incomplete, and could include, for example, the number of SWAps GFATM supports as a share of existing SWAps. Similar indicators could be developed for other issues, although some aspects of harmonization are inherently difficult to measure.

iv) Impact of GFATM funding on HIV/AIDS, TB, and malaria. Impact is the ultimate objective but it is the toughest to measure since it takes a longer time and GFATM's

influence relative to other factors is difficult to disentangle. GFATM is just beginning to develop its approach in this area. It plans to develop indicators and systems for this purpose in 2005 and incorporate these into reporting systems in the medium term.

Key Points:
- Substantial progress has been made in establishing the measurement framework, but there is ample room for further improvement.
- There are tensions between GFATM's mandate to focus vertically on three diseases, measure performance, and show additionality while harmonizing with SWAps.
- GFATM needs to develop systems that are flexible enough for a range of country systems while maintaining comparability across countries. Similarly, partners must be willing to adjust their systems to accommodate GFATM's mandates.

4. Performance to Date

4.1 GFATM's performance can be gauged through information made available from the Secretariat, along with the conclusions of several dozen outside studies, most of which have focused on process issues (Annex 10). The consistent message from these analyses is that GFATM has made important progress but difficult challenges remain.

4.2 ***Generating Financial Resources***. GFATM has attracted pledges of $5.9 billion and contributions of $3.3 billion (the U.S 33%, the E.C. 14%, and the U.K. 4%. Although these amounts are substantial, going forward the challenge is greater. GFATM projects it will need an average of $3.6 billion in 2006-07 for anticipated renewals and one or two new proposal rounds. Global requirements for the three diseases are expanding dramatically: the WHO estimates they will reach $14 billion in 2007.

The Fund's Comprehensive Funding policy limits the Secretariat to signing grants only if 100% of the funds are in hand, a very conservative approach. The policy is driven by GFATM's uncertain funding base and the desire to provide certainty to grantees, but it results in the Fund continuously holding cash balances of about $2 billion. There are ways to adequately manage risks with smaller cash balances. The Fund is reviewing this policy and it will be a major focal point during replenishment discussions.

4.3 ***Grant processing and disbursements***. GFATM has approved 310 grants in 127 countries, committing $3.1 billion for the first two years. It has signed $2.1 billion (67%) in formal agreements, and disbursed $878 million (equivalent to 28% of commitments and 42% of signed agreements) (See Annex 5). Although these are large numbers for a new organization, grant processing time and disbursement speed have been major concerns. Although the pace has accelerated, there is ample room for improvement.

- The time from Board approval to grant signing dropped from 370 to 271 days between rounds 1 and 2, but grew to 300 days in round 3 (Annex 5, Figure 1).
- More promisingly, the average time from grant signing to first disbursement fell from 68 to 43 days between rounds 1 and 3. Non-government PRs have moved faster than others, averaging about one month faster than government PRs.

Once disbursements have started, broadly speaking they are on track: on average 50% has been disbursed during the first 52% of the life of the grant (Annex 5). Disbursements have been notably faster for non-government PRs. On average non-government PRs are about 3.5 months ahead of government PRs.

However, many countries report significant delays in disbursements from PRs to sub-recipients. Unfortunately GFATM does not track these data. Some PRs take a long time to negotiate agreements with sub-recipients. Senegal just completed negotiations with subs on its round 1 grant, and has disbursed nothing. Some governments do not have appropriate procedures and are reluctant to disburse to NGOs.

There is an obvious tension between speed and the need to establish strong oversight systems. Although the process has accelerated, no one is satisfied with the current speed. There are several reasons for slow disbursements:

- Changes in leadership or conflicts between key actors,
- Unforeseen events (such as in Haiti or Sri Lanka),
- Weak recipient capacity,
- Poor performance against targets,
- Lack of clarity, communication, and follow-though from GFATM.

With current information it is not possible to apportion responsibility among these and other causes for delays, but all are important. We examine possible remedies below.

4.4 ***Grant performance and substantive results***. Cumulative results for the grant portfolio as of the end of 2004 include:

- 130,000 people on ARV treatment for AIDS,
- more than 1 million people reached with voluntary HIV testing,
- 385,000 people treated under the DOTS TB strategy,
- 300,000 people received third-generation malaria drugs,
- 1.35 million families received insecticide-treated bed nets,
- 350,000 people trained to fight HIV, TB, and malaria.

GFATM has become the world's largest financier for artemisinin-based combination therapy for malaria and for bed nets, and is possibly the largest for ARVs.

Detailed information is available for the first 27 grants to reach the renewal stage, the first of more than 100 grants that will reach this stage in 2005 (Annex 7). Performance has been particularly strong on TB grants, the distribution of bed nets, and some service delivery (PMTCT testing, VCTs, and orphans). ARV treatment is behind schedule for these 27 grants, due mainly to procurement issues in Senegal and Uganda (similar issues have affected malaria drugs and bed nets), although according to the Secretariat, ARV performance for the overall portfolio now exceeds targets.

GFATM ranks grants with 4 grades: A = meeting or exceeding targets; B1 = adequate progress; B2 = inadequate but potential; and C = unacceptable. Of the fist 27 grants:

- 70% were rated either A (10 grants) or B1 (9 grants); 22% were rated B2 (6 grants) and 8% (2) were rated C (including Uganda).
- Performance in specific areas varied with grades. On ARVs, the A grants achieved 174% of targets, the B1 grants achieved 61%, and the B2 and C grants achieved just 21%.
- Money has followed performance: the A, B1, B2 and C grants received 92%, 86%, 71%, and 45% of their expected disbursements, respectively.
- Performance has been strongest for non-government PRs (all rated A or B1) and more mixed for grants with government or UNDP PRs.

Several countries have exceeded expectations and achieved strong results. For example, Rwanda's HIV/AIDS program has administered VCT services to 110,400 people (115% of target), treated 7,284 people for sexually transmitted infections (130%

of target), and put 4,115 patients on ARV treatment (232% of target). Haiti has distributed over 780,000 condoms and provided HIV tests for 16,000 pregnant women.

4.5 ***CCMs, LFAs, and other processes.*** The Global Fund introduced a new way of designing programs and providing financial support in fighting the three diseases. Several outside studies have concluded that the Fund has made important progress, although much more needs to be done (Annex 10). They credit the Fund with establishing new processes rapidly, making aid performance-based, broadening participation, being very transparent, and showing a remarkable willingness to seek input and question its own structures. At the same time, modifications and changes are needed, a view shared in large part by the Secretariat. Some of the key issues include:

- CCMs function reasonably well in some countries (e.g., Rwanda and the Philippines) but less well in many others. The CCM concept opens new and significant opportunities for non-government actors to participate in key decisions. Nevertheless there are strong concerns about composition, government dominance, lack of integration with existing bodies, and weak incentives for CCM involvement after Board approval of proposals.
- The LFAs were envisaged as a way to bring private sector skills into assessment and monitoring and be the Fund's eyes and ears on the ground. However, they are costly, do not have strong competence in monitoring health indicators, have been slow to carry out assessments, and do not always provide adequate feedback from their assessments to CCMs and PRs.
- GFATM's policies often create significant new burdens. There are difficulties in harmonizing with existing systems, although there are many countries where adequate systems do not exist and must be developed.
- GFATM at times provides weak guidance and poor communication, which to some extent is a function of its small size and heavily-burdened staff.

4.6 ***Steps to improve performance***. GFATM recently has reviewed many of these issues, and is considering several possible changes to its "core business model:"

- Create incentives for the LFAs to complete the PR assessments more quickly.
- Subsume CCMs into existing bodies where those bodies are able to carry out its functions (with broad participation).
- Modify procedures to work through SWAps, as has been done in Mozambique.
- Modify (or even eliminate) the LFAs in country in which strong monitoring systems are in place, such as with SWAps.
- Encourage countries to nominate at least two PRs (one non-government) to ensure wider participation, ease government bottlenecks, and speed processes.
- Increase the number of GFATM country portfolio managers to ease bottlenecks. 18 were far too few; the current target of 48 still may be insufficient.
- Install a rating system for the CCMs and PRs to create incentives for better performance. Well-performing CCMs would proceed through an expedited process in subsequent rounds and could receive larger, more flexible funds.
- Initiate PR assessments when proposals are recommended by the Technical Review Panel, rather than after Board approval (usually one-two months later).
- The Board recently adopted new guidelines on CCM composition.
- Merge reporting requirements for PRs receiving multiple grants.

Some of these modifications seem very sensible, while others require deeper consideration and debate. *An important goal should be to help countries move closer to achieving the "three ones" for HIV/AIDS: one national action framework, one national coordinating authority, and one monitoring and evaluation framework*. The success in

several countries (e.g., Rwanda, Haiti, China) shows that GFATM grants can be successful, and the Secretariat's willingness to adapt its systems in other places (such as Mozambique's SWAp) suggests that performance can be improved in other countries. Making these improvements happen will require concerted efforts by the Secretariat, host government, and other partners, including DFID.

Key Points:

- GFATM has shown significant progress in its first three years. It has raised substantial amounts of funding and quickly (perhaps too quickly) established new systems. Some programs are beginning to show impressive results.
- Concerns remain about its funding policies, the speed of grant processing and disbursement, and the adequacy and efficacy of the systems it has put in place.
- GFATM has shown remarkable openness and willingness to be self-critical, providing the basis for improving performance. Most analysts believe that with some modest changes, GFATM can be successful.
- Making these changes will require strong efforts by GFATM (possibly requiring additional staff), governments, local agencies, and other partners, including DFID.

5. Country cases: Uganda, Kenya, Mozambique and Zambia

5.1 This study arose from concerns about GFATM performance in Uganda and Kenya. This section reviews progress and performance in those countries and two others:

- *Mozambique*, the first country in which GFATM is fully participating in a SWAp.
- *Zambia*, where most participants consider GFATM programs successful. Zambia provides an example of multiple (four) PRs, including an NGO and a faith-based organization, in contrast to Uganda's Ministry of Finance as sole PR.

Details of individual country programs are given in Annex 8.

In all four countries, progress has been markedly slower than original expectations. Nonetheless, in Zambia and Mozambique disbursements are largely on track, and real benefits are being brought to those in need. For example, GFATM has provided strong support to Zambia's new policy of free antiretroviral treatment, and rollout of a national ACT programme for malaria treatment. In Uganda and Kenya, programs are off-track. Responsibility lies with both the GFATM secretariat and country level management.

5.2 ***Common findings.*** There are several concerns common to each country:

- *GFATM guidance* has changed frequently, occasionally been applied retrospectively (e.g., to approved Round 1 applications) and sometimes come late (e.g., on the role and responsibilities of CCMs). Countries have felt both uncertain and that the goalposts were moved. But, in part at least, changes in guidance have reflected GFATM's willingness to modify its systems.
- *Communications* have been weak, both between GFATM and the country, and within countries. Lack of a GFATM country presence presumes active support for countries from multilateral and bilateral partners. But in some cases these partners have felt inadequately informed, or at worst marginalized.
- *Rapid turnover of overburdened GFATM Portfolio Managers,* (some of whom have lacked appropriate experience), has compounded communications problems and impeded follow-up. GFATM's planned increase in the number of Portfolio Managers should help, although more with higher skills may be needed.
- *Burdensome and bureaucratic processes*.

At country level, it has taken time to get supporting arrangements functional:

- *CCMs* were established quickly and some have been restructured. Key concerns include the CCMs' fit with existing coordination bodies; insufficient attention given to accountability and transparency; conflicts of interest where the PRs sit on the CCM (and PR isolation where they do not) and where NGOs are representing a constituency as well as receiving direct funding; and CCMs' lack of focus on their oversight role.
- *Administrative structures* had to be established, which was especially difficult where the Ministry of Finance (MoF) was the PR. Kenya has appointed a Program Coordinator within the Ministry of Finance (MoF), and Program Managers to monitor each component within the Ministry of Health (MoH). Uganda has delegated responsibility to the Permanent Secretary of the MoH and a (highly paid) off-line Project Management Unit (set up apparently to meet GFATM additionality requirements). There are concerns about lack of supervision of the Unit, and broader oversight of the GFATM program.
- *New financial management arrangements* were required.
- *Procurement mechanisms* have been a protracted problem in Uganda and Kenya until very recently.
- *Local Fund Agents (LFAs)* have had to develop understanding of the issues. In Mozambique, the LFA changed mid-assessment.

5.3 ***General conclusions.*** On the whole, these are fundamentally start-up issues – getting new structures and processes in place and understood at country level and within GFATM. Early rhetoric about rapid disbursement underestimated the time needed. Latest reports suggest that many of these issues have been or are being worked through, at least in terms of getting arrangements into place. Some are very recent. (In Uganda, the Crown Agents became the 3rd party procurement agency only in December 2004). Working relationships are still being sorted out. Proof of effectiveness has yet to be demonstrated in markedly accelerated disbursement and implementation.

There remain future operational challenges. Few programs started before 2003. GFATM and recipient countries are still working through the first full 5 year cycle, and novel processes are being developed at each stage. The immediate task is handling the performance review over the first two years of Round 1 grants, and applications for extension. Delays to date in country performance could jeopardise Phase 2 funding, (eg in Uganda).

GFATM is showing greater willingness to tailor requirements to countries. In Zambia, the GFATM reporting cycle has been adjusted to fit country monitoring periods, and GFATM is moving towards joining the SWAp. But much more needs to be done to reduce the general burden of GFATM bureaucratic processes, consistent with proper accountability. GFATM has outlined possible proposals for a new business model (outlined earlier), which are currently under discussion. Pilots are to take place in Zambia and Swaziland.

5.4 *Improving GFATM alignment*. Mozambique is the first country where GFATM is participating in a SWAp. In the process, the Secretariat has been pragmatic and willing to take some risks, albeit not always quickly. For example, it waived assessment requirements as preconditions for disbursing to the SWAp, given partners' close oversight of SWAp mechanisms. It made the first major disbursements ($15 million) in December 2004, despite an adverse recommendation from the LFA.

The agreement in Mozambique provides the basis for practical arrangements in a wider range of SWAp countries, such as Uganda and Zambia.

During a recent Secretariat mission to Uganda (10-17 February 2005), it was agreed that two consultancies should be undertaken: (i) to explore by end June 2005 the use of existing national coordination bodies in place of the CCM; and (ii) to advise on options for GFATM participation in the SWAp, taking into account principles of additionality and performance-based programmatic funding. This study is expected to be completed before the health partners' MOU is signed in July 2005. DFID Uganda has undertaken to fund and arrange these consultancies. The mission aide memoire also set out clear timelines for key actions to expedite implementation.

In countries like Ghana, where discussions are already underway, GFATM should move swiftly to agree firm proposals for disbursing through the SWAp.

5.5 **Two Immediate actions**

i) Action plan for Uganda. Uganda has become a totem. Whatever the different perspectives about past poor performance, the present position seems to be that at last the basic organisational arrangements are in place. Disbursements have been made to NGOs, faith-based organisations and private sector entities. Procurement should scale up. The recent mission aide memoire provides the basis of a strategic action plan, including active development of proposals for the GFATM to participate in the SWAp and use existing coordination bodies. DFID assesses the outcome of the February mission as very positive.

ACTION: Given a history of lax follow-up, it is critical that the GFATM Secretariat works closely with GoU to facilitate early delivery of (a) agreed key targets and activities to accelerate effective implementation; and (b) a timetabled process for GFATM to enter the SWAp. DFID and other partners can provide support to resolve problems. DFID has already offered to fund consultancies. A joint high-level mission may be useful to finalise agreements.

ii) *Improved GFATM procedures*. More broadly, GFATM needs a strategy for reducing bureaucratic procedures and improving alignment with country processes, possibly on a tailored basis. Some problems (e.g., misaligned reporting periods) could potentially apply to most recipient countries. Many issues and options have already been raised in the context of GFATM's discussion of its core business model.

ACTION: DFID should seek to influence GFATM to develop (a) specific measures to reduce bureaucratic procedures, and (b) a strategy for engagement with SWAp countries. The latter would require a broad strategy, modified as needed on a country-by-country basis. DFID could offer to help develop this strategy. The presumption should be that GFATM would operate through SWAps wherever they are sufficiently robust.

Key points:

- Progress varies across countries. Time needed to establish new structures and processes was under-estimated. There have also been avoidable delays.
- GFATM should agree specific measures to reduce the level of bureaucracy, and a plan of engagement with SWAp countries.
- For Uganda specifically, GFATM should work closely with GoU to secure accelerated and effective implementation and GFATM participation in the SWAp.

6. Comparison to Other Mechanisms

6.1 **The World Bank's Multi-Country HIV/AIDS Program for Africa (MAP)** was initiated in 2000. In its first 4.5 years, MAP has committed about $1.1 billion to 34 countries in sub-Saharan Africa and disbursed $376 million (34%). As a multilateral AIDS initiative, it is probably the closest parallel to GFATM, although it differs in many ways (e.g., no malaria and TB component). Unfortunately, the Bank is far less transparent than GFATM, so there is very little public information on disbursements, programmatic descriptions, or results. A recent Bank review concluded that "experience with implementation of individual projects and sub-projects has been mixed and often disappointing.[1]" It provides no information on substantive results. The widespread perception is that MAP suffers from long delays in establishing programs and disbursing funds and is subject to bureaucratic difficulties. There is no systematic monitoring and evaluation system. Although it is two years older than GFATM and operating through an existing institution, its commitments in sub-Saharan Africa ($1.1 billion) are about two-thirds the size of GFATM's ($1.8 billion).

6.2 **The US President's Emergency Plan for AIDS Relief (PEPFAR)**. PEPFAR has been widely criticized for its approach: bilateral, very little country participation in setting priorities, country targets established in Washington, no attempt at coordination or harmonization (including SWAps), and controversial positions on generic drugs, abstinence, and condoms. It operates in parallel with, but not through, host country governments. It provides very little public information on its activities. Nevertheless, there is no question that it is moving very quickly to scale up activities. Unlike GFATM, it was not a start-up organization. Rather, it has built on existing projects and has not had to establish new systems. It budgeted $264 million for 12 African countries in 2004 and $781 million in 2005, and the President recently requested $1.2 billion for these countries in 2006 (including $186 million and $162 million for Uganda and Kenya, respectively – see Annex 9). PEPFAR will move more quickly than GFATM in a smaller number of countries and is likely to claim some quick results, but its sustainability and impact on local institutions remains to be seen. With its vast differences, it should be seen as a useful but only partly informative benchmark for GFATM.

6.3 **The U.S. Millennium Challenge Account**. This program has little to do with HIV/AIDS, but like GFATM it is a recent start-up, with entirely new procedures and operations. Like GFATM, it focuses on country-led programs with a strong focus on results. In some ways it should have been easier to establish, as it involves only the US government and is focusing initially on 17 countries. However, three years after the President announced the program, it has yet to disburse a single dollar. Its first proposal arrived in June 2004; no grant agreements have yet been signed.

[1] "Interim Review of the Multi-Country HIV/AIDS Program for Africa" (October 2004), page ii, www.worldbank.org/afr/aids/map.htm

LIST OF ANNEXES

Annex 1: Abbreviations

ARV	Antiretroviral drug
CCM	Country Coordinating Mechanisms
CSO	Civil society organisation
DFID	UK Department for International Development
DOTS	[TB] directly observed therapy (short course)
GFATM	Global Fund to Fight AIDS, TB and Malaria
GoU	Government of Uganda
LFA	Local Fund Agent
MAP	Multi-Country HIV/AIDS Program for Africa [World Bank]
MoH	Ministry of Health
MoF	Ministry of Finance
MOU	Memorandum of Understanding
NAC	National AIDS Council
NGO	Non-governmental organisation
PEPFAR	US President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission (of HIV/AIDS)
PMU	Project Management Unit
PR	Principal recipient
SWAp	Sector-wide approach
TA	Technical Assistance
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Annex 2: Comparison of Staff Size

Disbursements and Staff Size for Selected Foundations, Private Corporations, and Bilateral and Multilateral Donor Agencies, 2003.

Organization	Total Staff	Funds Disbursed/Budget	Funds per Staff
		$ millions	$ millions
Asian Development Bank	2,163	5,300	2.5
Bank of America	133,944	365,447	2.7
Bill and Melinda Gates Foundation	238	1,012	4.3
Citigroup	250,000	436,304	1.8
David and Lucille Packard Foundation	160	230	1.4
DFID	2,257	3,310	1.5
Ford Foundation	600	931	1.6
International Fund for Agricultural Development	315	450	1.4
Inter-American Development Bank	1,770	7,900	4.5
International Financial Corporation (IFC)	2,000	3,100	1.6
Kellogg Foundation	205	223	1.1
MacArthur Foundation	192	180	0.9
National Science Foundation	1,300	4,500	3.5
Pew Charitable Trusts	140	230	1.6
The Open Society Institute (Soros Foundation)	500	261	0.5
Turner Foundation	16	70	4.4
USAID	6,910	8,800	1.3
World Bank	10,000	19,500	2.0
GFATM as of June 2004	80	400	5.0
GFATM projected end 2005	130	1,400	10.8

Source: Radelet , 2004. Based on information available from organization websites and personal communications with the institutions.

Annex 3: Performance Measures

GFATM is introducing a performance measuring system with four levels. The overall approach and details on the first two levels were approved by the Board in 2004, while details on the third and fourth levels are still under development.

1) ***Institutional operations*** with specific indicators including:
   - Resources contributed relative to pledges and targets
   - Grants signed as a share of grants approved
   - Proposal handling time (from call for proposal to grant signing)
   - Disbursements relative to targets
   - Operational costs as a share of total expenditures and relative to targets

The Secretariat recently introduced a new management tool (the "Executive Dashboard") to facilitate ongoing monitoring of these and other indicators. This system is supplemented by periodic internal and external studies. For example, the Secretariat recently commissioned a study on the effectiveness of Local Fund Agents (LFAs), and there have been numerous studies (some commissioned by GFATM and others wholly independent) on the Country Coordinating Mechanisms (CCMs).

2) ***Grant performance.*** Each grant includes 15-20 or so specific indicators such as:
   - Number of people on anti-retroviral treatment
   - Number of voluntary testing and counseling centers established
   - Number of clients receiving testing and counseling
   - Number of condoms or bednets purchased and distributed
   - Number of health workers trained
   - Number of radio advertisements produced and aired.

Progress against these indicators is reported by the LFA to the Secretariat on a quarterly basis and when the CCM makes requests for disbursements. When countries request grant renewal at the end of the first two years, GFATM posts on its website the grant renewal reports that provide detailed information on progress on each indicator.

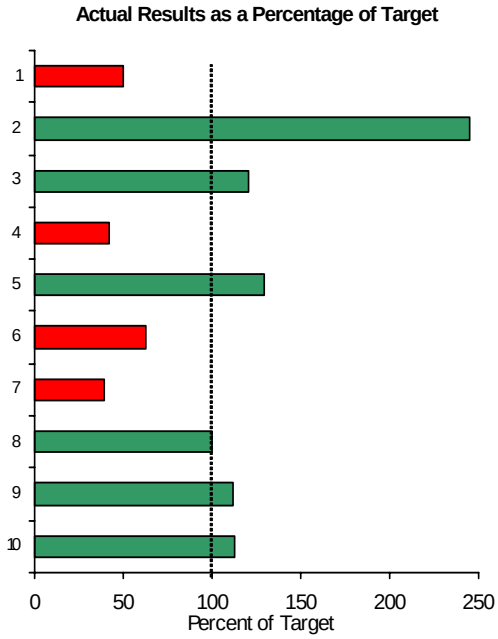
3) ***System effects*** focusing on three areas:
   - Additionality of finances, including levels and trends of donor assistance; public and private spending on development, health, and the three diseases; progress in meeting "unmet needs" in the three diseases.
   - Long term sustainability, including drug and commodity prices; government spending on health and the three diseases; and pledges and contributions to GFATM looking ten years forward.
   - Partnerships, including number of joint activities with other agencies towards harmonization; countries with national strategies that refer to GFATM activities, and several measures of CCM composition and processes.

4) ***Impact*** on the three diseases, for which GFATM plans to develop indicators and systems in 2005 and incorporate these into grant reporting systems in the medium term.

Annex 4: Example of Grant Performance Report

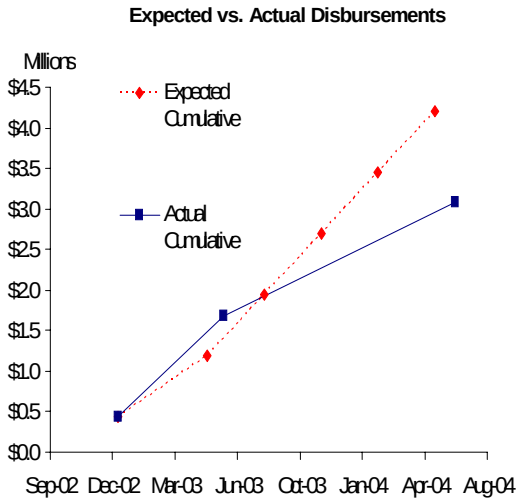
Results to Date

	Indicator	Year 1 Target	Year 1 Actual	Percentage of Target
1	Number of people with advanced HIV infection receiving ARV combination therapy per year	1200	595	50%
2	Training of personnel to provide home care services	516	1266	245%
3	Number of districts teams trained in home care	28	34	121%
4	Number of mother/child pairs reached with PMTCT services	600	250	42%
5	Number of new centers offering PMTCT services	7	9	129%
6	Number of income-generating projects for PLWHAs	24	15	63%
7	Number of patients treated for OIs	3000	1178	39%
8	Number of new health facilities capable of providing advanced interventions for prevention and medical treatment for HIV infected persons	2	2	100%
9	Number of people attending for VCT	1560	1745	112%
10	Number of new VCT centers	8	9	113%

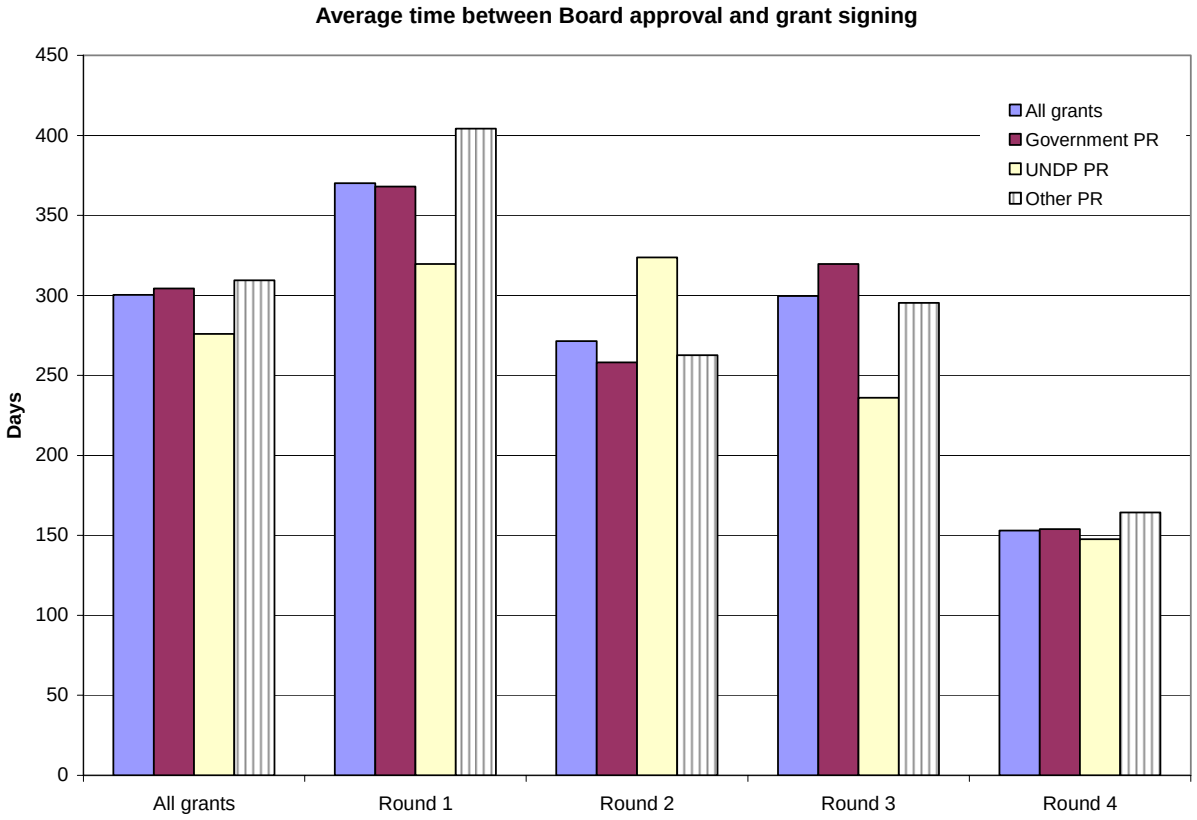


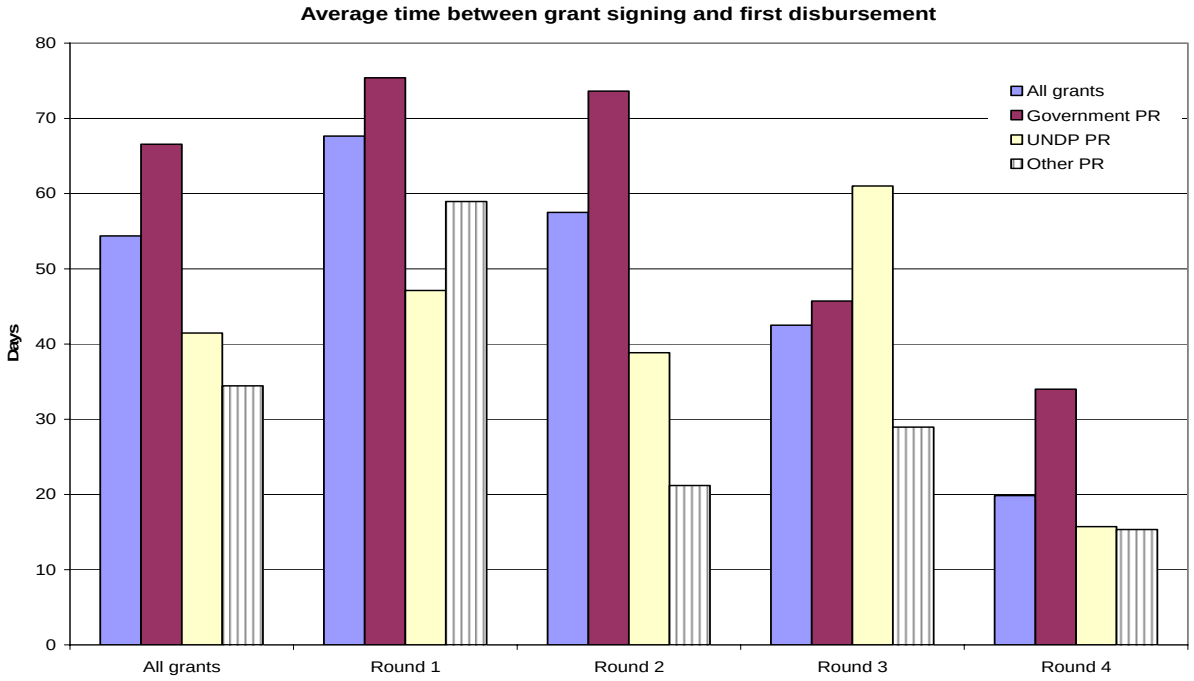
Disbursements to Date

	Date		Amount		Cumulative	
	Expected	Actual	Expected*	Actual	Expected	Actual
1		18/12/02		$429,599	$429,599	$429,599
2	10/05/03	06/06/03	$755,980	$1,246,900	$1,185,579	$1,676,499
3	10/08/03	11/06/04	$755,980	$1,404,088	$1,941,559	$3,080,587
4	09/11/03		$755,980		$2,697,539	
5	08/02/04		$755,980		$3,453,519	
6	09/05/04		$755,980		$4,209,499	

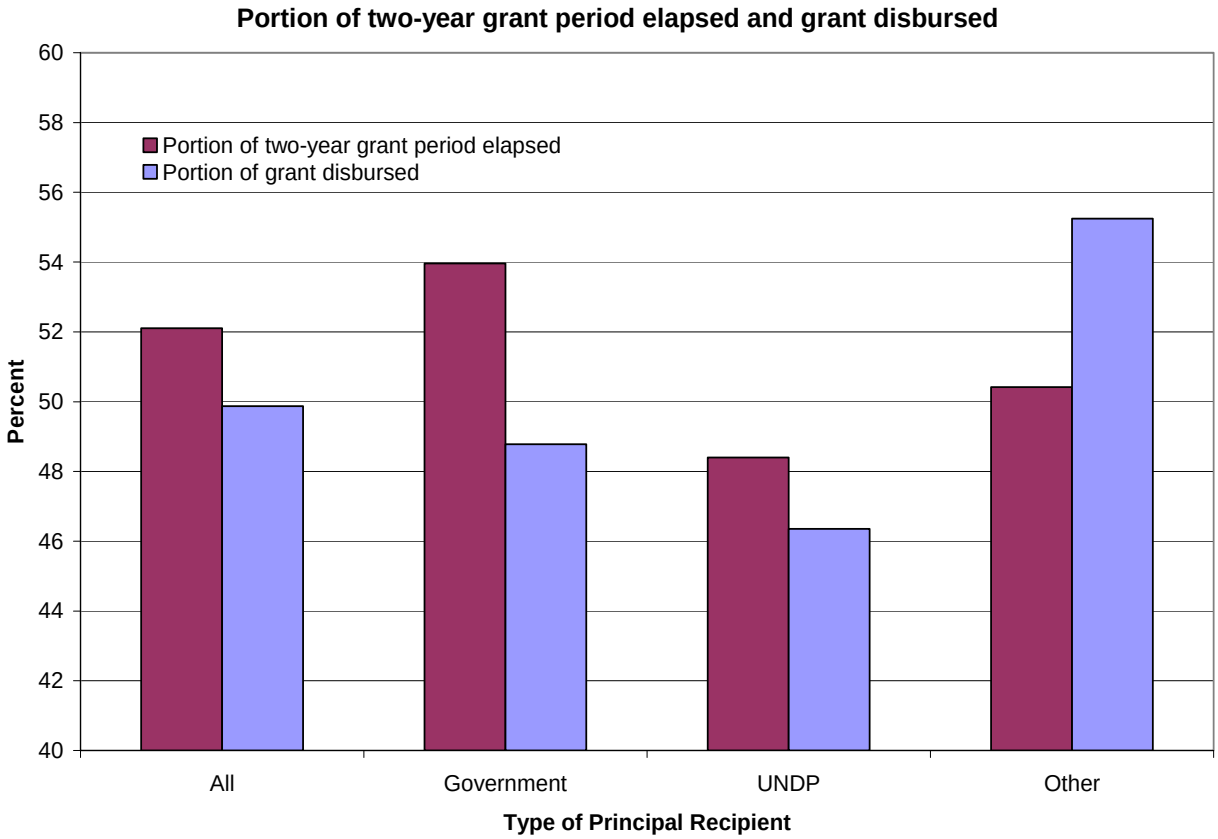


Annex 5: Grant Processing and Disbursement Speed



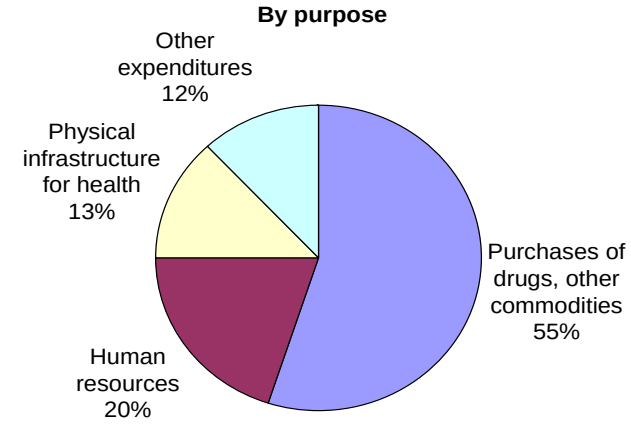


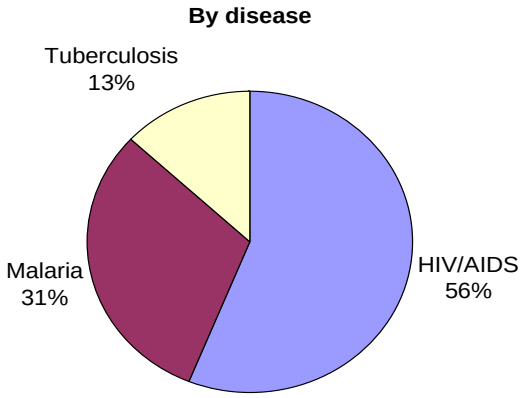
Averages for the first 236 grants to reach their first disbursement.

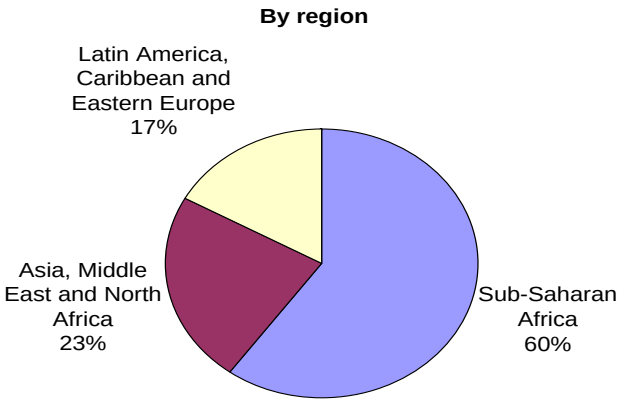


Averages for the first 236 grants to reach their first disbursement.

Annex 6: Distribution of Grants







Annex 7: Performance Indicators for First 27 Renewal Grants

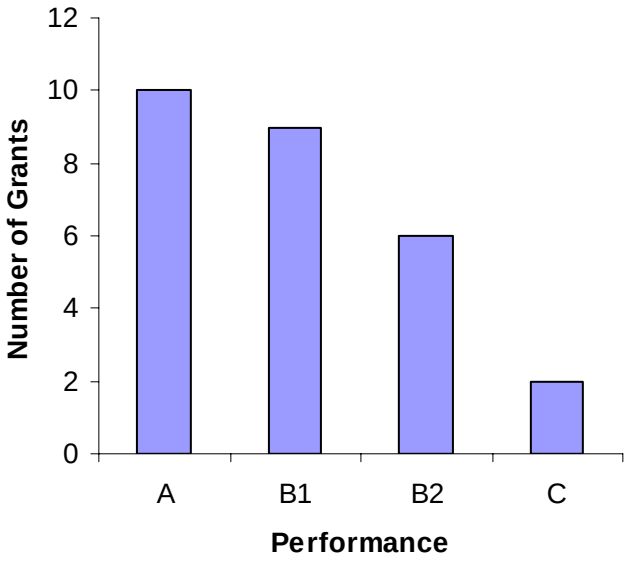
Annex Table 7.1. Selected Indicators and Performance of 27 Grants

HIV/AIDS	% of targets	Tuberculosis	% of targets
ARVS	61%	DOTS	101%
PMTCT Prophylaxis	72%	People Reached	112%
PMTCT Testing	121%	People Trained	105%
VCTs	122%		
Orphans	116%	**Malaria**	
People Reached	60%	Bed nets	107%
People Trained	62%	Malaria Treatment	79%
		People Reached	91%
		People Trained	79%

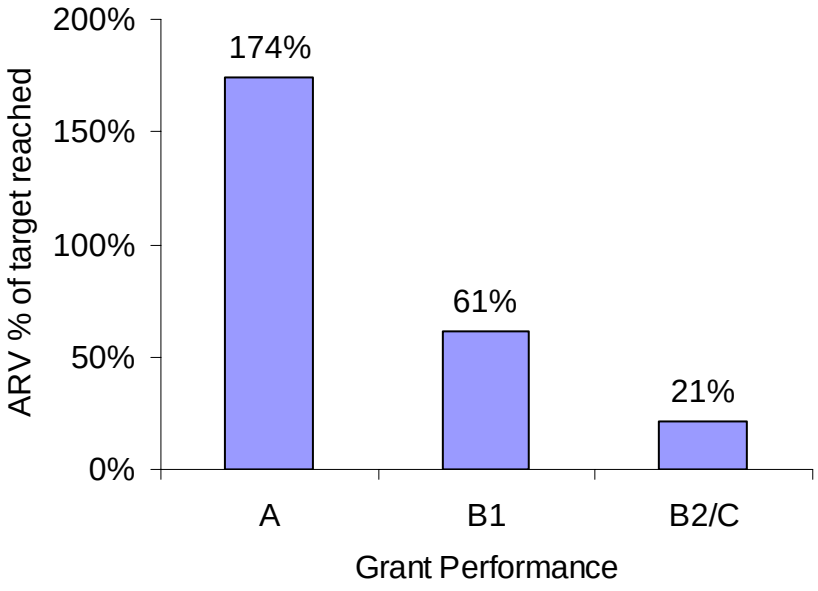
Annex Table 7.2. Summary of 27 renewal grants

Country	Round	Disease	2 yr budget ($ mill)	Principal Recipient	Performance Rating on Targets
Benin	1	Malaria	2.4	UNDP	B1
Burundi	1	HIV/AIDS	4.9	National AIDS Council	B1
China	1	TB	25.4	Chinese CDC	A
China	1	Malaria	3.5	Chinese CDC	A
Ghana	1	HIV/AIDS	5.0	MOH	B1
Ghana	1	TB	2.3	MOH	B1
Honduras	1	HIV/AIDS	12.6	UNDP	B2
Honduras	1	TB	3.8	UNDP	B2
Honduras	1	Malaria	4.1	UNDP	B2
Haiti	1	HIV/AIDS	17.9	Foundation SOGEBANK	A
Haiti	1	HIV/AIDS	6.8	UNDP	B1
India	1	TB	5.7	Dept of Econ Affairs	A
Laos	1	HIV/AIDS	1.3	MOH	B2
Laos	1	Malaria	3.2	MOH	B2
Madagascar	1	Malaria	1.8	Pop Services Int.	B1
Madagascar	2	HIV/AIDS	0.7	CRS	A
Madagascar	2	HIV/AIDS	3.0	Pop Services Int.	B1
Moldova	1	HIV/TB	5.3	MOH	A
Mongolia	1	TB	0.6	MOH	A
Morocco	1	HIV/AIDS	4.7	MOH	A
Panama	1	TB	0.4	UNDP	A
Rwanda	1	HIV/TB	8.4	MOH	A
Senegal	1	HIV/AIDS	6.0	National AIDS Council	C
Senegal	1	Malaria	4.3	MOH	C
Tajikistan	1	HIV/AIDS	1.5	UNDP	A
Tanz/Zanzibar	1	Malaria	0.8	MOH/Zanzibar	B1
Uganda	1	HIV/AIDS	36.3	MOF	C

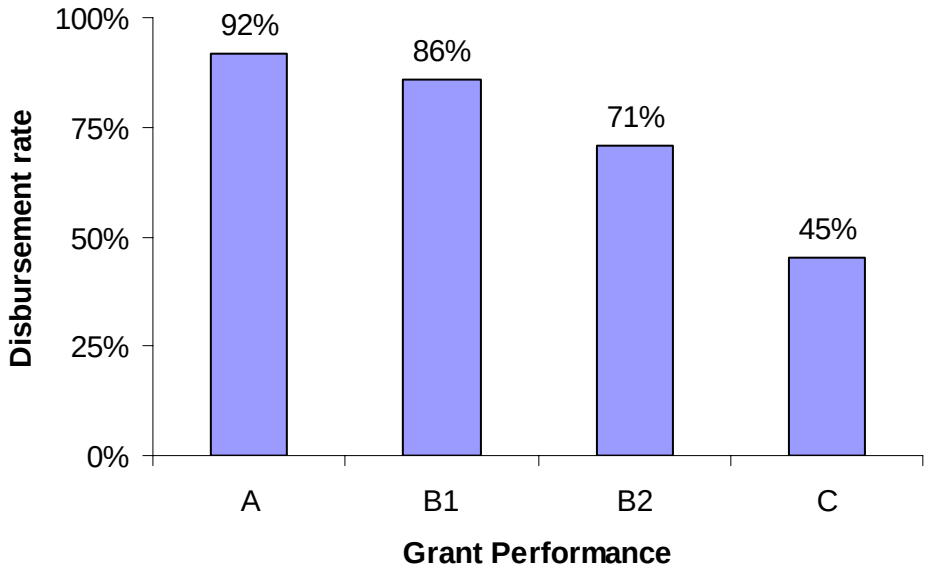
Annex Figure 7. 1: Number of grants by performance category



Annex Figure 7.2: Variation in ARV performance by grant category



Annex Figure 7.3: Percentage of expected money disbursed by grant performance



Annex 8: Country Case Studies
Uganda, Kenya, Mozambique and Zambia

Introduction

This study arose from concerns about GFATM performance in two countries: *Uganda* and *Kenya.*

It has therefore reviewed progress and performance in those countries and two others:

- *Mozambique*, as the first country in which the GFATM is fully participating in a SWAp.
- *Zambia*, as a country whose GFATM program is considered a success. Plus it provides an example of multiple Principal Recipients per grant – four PRs including an NGO and a faith-based organization, for a Round 1 HIV/AIDS grant, in contrast to Uganda's approach of the Ministry of Finance as the sole PR for all grants.

Key findings and conclusions from the case study review are given in section 5 in the main report. This annex provides brief details of the current position in relation to the GFATM programs in the four study countries.

Uganda

Grants

An initial integrated Round 1 proposal was rejected by the GFATM; a replacement Round 1 proposal for HIV/AIDS was successful. The GFATM has subsequently approved two applications in Round 2 for malaria and TB, an HIV/AIDS application in Round 3, and a further malaria application in Round 4. The total approved year 1+2 budget is $201,007,993.

The Principal Recipient for all five grants is the Ministry of Finance, Planning and Economic Development. In practice, day to day responsibility has been delegated to the Permanent Secretary of the Ministry of Health, who is supported by a Global Fund Project Management Unit (PMU). The Government of Uganda (GoU) is reported to have projectised GFATM support and established the PMU in order to meet GFATM's additionality requirements. Oversight relationships for the PMU need to be clarified. The CCM has a continuing role in overseeing implementation, as well as preparing new applications.

GoU had raised the issue that areas such as nutrition, human resources for health and integrated health systems proposals were key to achieving the GFATM's aspiration but were not supported. Proposals to include these areas in Round 5 Proposal Guidelines are to be considered by the GFATM Portfolio Management and Procurement Committee 15-16 February 2005.

Performance and Disbursements

Permanent Secretary, DFID, undertook a joint mission to Uganda in January 2005 with the Executive Director of UNAIDS and others. The mission note noted that 'systemic blockages have inhibited rapid disbursement and effective utilisation of some sources of finance, particularly the GFATM. Government and the GFATM secretariat should review ways to improve disbursements overall and the flow of GFATM resources to communities and civil society organizations'.

Delays have been caused by a number of factors, including:

- the GoU's establishment of a Project Management Unit from scratch
- development of appropriate financial management systems
- the slow selection of, and disbursement to, civil society organisations (CSOs), leading to complaints from civil society
- the requirement for 3rd party procurement
- high turnover of GFATM Portfolio Managers, and lack of consistency in follow-up.

Past performance has been poor. Approval of Phase 2 funding could be jeopardised. But some of the key 'blockages' have recently been cleared and a new Portfolio Manager has been appointed to work only on Uganda. There must now be a determined effort on all sides to accelerate disbursement and implementation. The GFATM Executive Director visited Uganda in November 2004, and a GFATM Secretariat mission visited Uganda 10-17 February 2005 to ensure follow-up. The mission aide memoire set out clear timelines for key actions to expedite implementation. The present position is that:

- disbursements have now been made to NGOs, faith-based organisations and private sector entities.
- a workplan for rapid catch-up by June 2005 of delayed results from the Round 1 HIV/AIDS grant is to be agreed by 15 March 2005
- workplans, budgets and targets for a combined Round 2 and Round 4 malaria grant are to be finalized by 1 March 2005. The grant agreement should be signed by 15 March 2005.
- the Crown Agents were appointed as the third party procurement agency with effect from 1 December 2004. This should provide the basis for accelerated scale-up.

Coordination of development assistance in Uganda

Wider issues between the GoU and its partners, and the GFATM include the GFATM's participation in Uganda's health SWAP, a mutually acceptable approach to meeting the GFATM's additionality requirement, and the need for a CCM. DFID strongly presses the urgent need for the GFATM in Uganda to be part of the health sector strategic plan and support existing systems of coordinating the AIDS response.

During the recent Secretariat mission, it was agreed that two joint consultancies should be undertaken: (i) to explore by end June 2005 the use of existing national coordination bodies in place of the CCM; and (ii) to advise on options for GFATM participation in the SWAp, taking into account principles of additionality and performance-based programmatic funding. This study is to be completed before the health partners' MOU is signed in July 2005. DFID Uganda has undertaken to fund and arrange these consultancies.

Overall DFID Uganda assesses the outcome of the February mission as very positive. The key need now is for all partners to ensure rapid follow-up.

Country: UGANDA **LFA:** PricewaterhouseCoopers

Round	Disease	Source	Yr 1+2 budget	Total budget	Principal recipient	Grant signed	Grant amount USD	Amount disbursed	% disbursed	% time elapsed	
1	HIV/AIDS	CCM	36,314,892	51,878,417	MoFPED	6/3/03	36,314,892	26,160,888	72%	90%	*-18%*
2	Malaria	CCM	23,211,300	35,783,000	MoFPED	27/2/04	23,211,300	9,749,358	42%	46%	*-4%*
2	TB	CCM	4,692,021	5,713,081	MoFPED	15/3/04	4,692,021	2,055,027	44%	46%	*-2%*
3	HIV/AIDS	CCM	70,357,632	118,565,707	MoFPED	1/10/04	70,357,632	0			
4	Malaria	CCM	66,432,148	158,047,079	MoFPED	Not signed					
Total			**201,007,993**	**369,987,284**			**134,575,845**	**37,965,273**			

Kenya

Grants. Kenya had two small Round 1HIV/AIDS grants submitted by NGOs who became PRs. Subsequent grants originated with the CCM. The Ministry of Finance is the PR for three Round 2 grants for HIV/AIDS ($36m), malaria ($10.5m) and TB ($5m). There are two sub recipients, the Ministry of Health and the National AIDS Control Council, with a Financial Management Agent to manage the NGO disbursement. An $82m Round 4 grant for malaria was cleared for signing on 16 February 2005.

Performance and Disbursements. Both Round 1 grants were fully disbursed on time. Even so Round 1 required stopgap funding from DFID due to problems with the approval process in the CCM.

Disbursements in Round 2 grants have been slow, caused by:

- very slow approval of the procurement consortium due to interference in the process. A GTZ, Crown Agents and KEMSA consortium is now operational. Government procedures of unrestricted tendering also slowed the process but procurement is now moving ahead as the consortium is well versed with government systems.
- weak and autocratic management of the CCM with insufficient attention to accountability and transparency. This increased the time required to make decisions and approve proposals and progress reports.
- deficiencies in progress reports (narrative but particularly financial) for the first grant of $6 million, which were unacceptable to the LFA and CCM. DFID Kenya advises that release of further funds was quite correctly held up pending review of reports.
- earlier lack of administrative support. The Head of External Finances is now leading on this personally and has appointed a Program Coordinator to monitor the GFATM Program, and Program Managers have been put in place in the Ministry of Health to monitor each subcomponent and hold regular meetings with various recipients. Early signs are showing that this will make a difference to performance.
- the time taken to establish the Financial Management Agency needed to undertake disbursement to civil society. It is now in place but finding that many NGOs need considerable support to set up systems before funds can be released. NB The GFATM have advised that the workplan had no provision in its first two quarters for disbursement to NGOs, to allow time to set up the agency. Planned third and fourth quarter disbursements to NGOs have been made.

Overall, there is no doubt that GFATM underestimated the time required to set up the necessary systems to spend funds and that this problem was exacerbated internally in Kenya. However, DFID Kenya advises there is now some optimism that progress will be made in effective utilization of the GFATM grants in Kenya.

Country: KENYA **LFA:** KPMG

Round	Disease	Source	Yr 1+2 budget	Total budget	Principal recipient	Grant signed	Grant amount USD	Amount disbursed	% disbursed	% time elapsed	
1	HIV/AIDS	NGO	2,650,813	2,650,814	NGO	30/3/03	2,650,813	2,650,813	100%	92%	*+8%*
1	HIV/AIDS	NGO	220,875	220,875	NGO	30/3/03	220,875	220,875	100%	92%	*+8%*
2	HIV/AIDS	CCM	36,721,807	129,054,092	MoF	27/8/03	36,721,807	26,454,882	72%	62%	*+10%*
2	Malaria	CCM	10,526,880	33,586,810	MoF	23/6/03	10,526,880	4,640,447	44%	74%	*-30%*
2	TB	CCM	4,928,733	11,232,735	MoF	23/6/03	4,928,733	2,457,403	50%	74%	*-24%*
4	Malaria	CCM	81,972,711	186,319,508		Not yet signed					
Total			**137,021,819**	**363,064,834**			**55,049,108**	**36,424,420**			

Mozambique

Mozambique is the first country where the GFATM is fully participating in a SWAp.

Grants Following a rejected first round proposal, a Round 2 proposal with components for all 3 diseases was accepted, subject to clarification and some modifications. The Government of Mozambique has said that it does not intend to apply for further funds in the short to mid-term until the results of current grants can be assessed.

There are two Principal Recipients:
i) the Ministry of Health for grants for HIV/AIDS ($22m), TB ($9m) and Malaria ($12m), a total of $43m for 2 years;
ii) National AIDS Council (CNCS) for one HIV/AIDS grant for prevention ($7.7m).

The grant agreements were all signed in April 2004, though Board approval had been received in December 2002 (16 months). The delay was attributed to:

- lengthy processes to select Principal Recipients, sub-recipients and an LFA
- changes mid-assessment in (i) LFA and (ii) Portfolio Manager
- an agreement to put MOH GFATM grants through the MoH SWAp Common Fund and the NACS (CNCS) grant through the CNCS Common Fund, without earmarking.

Since the SWAp pooled mechanism had become operational only in January 2004, the Global Fund had concerns about its ability to manage and account for funds in a way consistent with the minimum requirements of the Fund. For example, a first disbursement by DFID in January 2004 did not reach the MoH until April 2004. After discussions, the GFATM agreed to:
- waive assessments as *preconditions* for contributing funds to the SWAp, given partners' close oversight of the SWAp;
- move to disbursement in line with partners at 6-monthly intervals.

Subsequent GFATM assessments found weaknesses in financial reporting and some gaps in the procurement plan. In lieu of an Institutional and Programmatic Appraisal, an innovative Compatibility Assessment compared the Common Fund MOU with the GFATM agreement and concluded that overall they were not incompatible.

Disbursements A (delayed) GFATM advance of $1m without condition was made in July 2004 to prime the pump pending completion of discussions about SWAp mechanisms. The first major MoH disbursements were eventually made in December 2004, despite an adverse recommendation from the LFA because of weak financial reporting systems. December disbursements total $15,384,567 across all 3 MOH grants. Disbursement is too recent to assess implementation.

The National Aids Council (CNCS) is managing substantial funds, including from MAP, and has not yet requested disbursement. Total funds not yet disbursed: $34,727,606.

Country: MOZAMBIQUE			**LFA:** Deloitte Touche Tohmatsu Emerging Markets								
Round	**Disease**	**Source**	**Yr 1+2 budget**	**Total budget**	**Principal recipient**	**Grant signed**	**Grant amount USD**	**Amount disbursed**	**% disbursed**	**% time elapsed**	
2	HIV/AIDS	CCM	29,692,640	109,338,584	NAC(CNCS)	2/4/04	7,732,956	Nil	0%		
					MoH	2/4/04	21,959,684	8,475,099	38%	28%	*+10%*
2	Malaria	CCM	12,217,393	28,205, 783	MoH	2/4/04	12,217,393	6,653,718	55%	8%	*+47%*
2	TB	CCM	9,202,140	18,190,995	MoH	2/4/04	9,202,140	1,255,750	14%	8%	*+6%*
Total			**51,112,173**	**155,735,362**			**51,112,173**	**16,384,567**			

Zambia

Grants Zambia was successful in receiving large awards in Round 1, when its application covered all three diseases, and in Round 4 for HIV/AIDS and malaria. Zambia has the highest number of Principal Recipients.

DFID assesses the GFATM's response to the HIV/AIDS challenges in Zambia as "very positive". GFATM funds are seen as crucial to continued services expansion for malaria (with national rollout of artemisin combination therapy), TB and ARVs. Implementation of Round 1 is near the end of its first phase. Round 4 agreements have not yet been signed. Zambia will be preparing a proposal for Round 5 which may include strategies to address human resource capacity needs.

For its Round 1 grants, Zambia selected four Principal Recipients, working in partnership within the overall Health Sector Plan. Two were from government (the Ministry of Finance and the Central Board of Health), one represented NGOs and one represented faith-based organisations.

Performance and Disbursements The arrangement has mostly worked well. The development of capacity in a civil society PR has provided a model for other donors, and had a positive system-wide effect. The exception has been the Ministry of Finance, which is supported by the National AIDS Council. It signed its HIV/AIDS grant agreement in December 2003 - later than other PRs - but no disbursements have yet been made.

Overall disbursement was seen as slower than initial expectations but not slower than by other donors. Significant communications problems at all levels, including loss of information sent to the LFA, contributed to delays. Changes in GFATM information needs (including retrospective requests for additional information on approved Round 1 proposals) wasted effort and created a sense of the goalposts being moved.

There has been concern over transaction costs to manage parallel funding and reporting, given Zambia's SWAp. Malaria control in Zambia is a vertical system with its own data collection, and GFATM indicators are based on those. The broad GFATM reporting cycle has been adjusted to fit country monitoring periods. The GFATM has stated that they can co-finance the basket, can accept aggregate indicators, and will reduce the frequency of PR reporting requirements. GFATM is waiting for the CBOH to propose a number of indicators where CBOH does not have national targets. There has been movement towards harmonization and alignment but what is needed now is to bring these proposals to fruition. DFID can support GoZ and the GFATM in achieving this. GFATM plans to pilot changes in its basic business model (including moving to a more programmatic approach) in Zambia and Swaziland.

Country: ZAMBIA			**LFA:** PricewaterhouseCoopers								
Rnd	**Disease**	**Source**	**Yr 1+2 budget**	**Total budget**	**Principal recipient**	**Grant signed**	**Grant amount USD**	**Amount disbursed**	**% disbursed**	**% time elapsed**	
1	HIV/AIDS	CCM	42,298,000	92,847,000	CBOH, Govt	30/3/03	21,214,271	16,936,307	80%	79%	*+1%*
					FBO	30/3/03	6,614,958	5,514,258	83%	79%	*+4%*
					MoFin	2/12/03	6,395,758	0	0%		
					NGO	22/5/03	8,073,013	6,002,482	74%	78%	*-4%*
1	Malaria	CCM	17,891,800	39,274,000	CBOH, Govt	15/8/03	17,039,200	16,093,535	95%	74%	*+21%*
					FBO	2/9/03	852,600	713,811	84%	68%	*+16%*
1	TB	CCM	14,755,256	48,682,000	CBOH, Govt	30/3/03	12,447,294	5,765,338	46%	78%	*-32%*
					FBO	30/3/03	2,307,962	1,870,872	81%	79%	*+2%*
4	HIV/AIDS	CCM	26,770,776	253,608,070		Not signed					
4	Malaria	CCM	20,279,950	43,495,950		Not signed					
Total			**121,995,782**	**477,907,020**			**74,945,056**	**52,896,603**			

Annex 9: PEPFAR Country Allocations

U.S. Budget Request: Global HIV/AIDS Initiative
($ in thousands)

	FY 2004 Actual	FY 2005 Estimate	FY 2006 Request
Africa			
Botswana	8,806	27,543	40,505
Cote d'Ivoire	7,523	20,912	29,906
Ethiopia	15,231	55,560	91,855
Kenya	34,631	107,020	162,348
Mozambique	11,083	45,884	57,757
Namibia	14,147	34,514	49,132
Nigeria	25,415	81,303	127,200
Rwanda	16,382	39,938	74,765
South Africa	31,787	101,859	150,698
Tanzania	25,027	80,326	104,672
Uganda	44,598	104,779	185,843
Zambia	29,210	81,831	131,587
Subtotal - Africa	**263,840**	**781,469**	**1,206,268**
East Asia and the Pacific			
Vietnam	10,000	22,145	28,015
Subtotal - East Asia and the Pacific	**10,000**	**22,145**	**28,015**
Western Hemisphere			
Guyana	5,097	13,153	21,362
Haiti	13,047	39,373	46,995
Subtotal - Western Hemisphere	**18,144**	**52,526**	**68,357**
Global			
Central Programs	129,797	251,231	392,825
International Partnerships	-	27,000	127,000
Other Bilateral Programs	16,500	35,000	50,000
Rapid Expansion Fund	-	117,000	-
Strategic Information/Evaluation	14,850	30,000	35,000
Technical Oversight and Management	34,972	57,549	62,535
Subtotal - Global	**196,119**	**517,780**	**667,360**
Total	**488,103**	**1,373,920**	**1,970,000**

ANNEX 10: Review of qualitative studies of the GFATM

Numerous studies of a moving target

The GFATM has been extensively studied from its establishment in January 2002. The study as a whole has drawn on the studies listed in Annex 10, as well as on a wide range of detailed GFATM public and internal working papers.

Because of the Global Fund's rapid evolution, studies can date quickly. The primary focus has to date been on process issues, particularly concerns and frustrations about GFATM processes. Most studies available were undertaken too early to assess achieved benefits.

This annex briefly highlights key points arising from a review of qualitative studies. The title of a 2003 US GAO study[1] encapsulates their overall message: "*GFATM has advanced in key areas but difficult challenges remain*".

Substantial progress

The GFATM made substantial progress in its first two to three years. Key findings include:

- a recognition of the potential of the GFATM as a radical new financial instrument to contribute to an exceptional response to tackling HIV/AIDS, TB and malaria.
- swift establishment of governance and other supporting structures, including the Board, the Secretariat, and the creation of CCMs in recipient countries[2].
- early success in raising substantial funding. Despite difficulty in judging how much is truly additional to amounts already programmed, a large part is clearly new money.[3]
- very rapid growth. In its first 2 years, the GF approved funding for over 220 programs in 122 countries, with signed 2-year grants totalling £1.24 billion[4]. Some timescales may have been too fast, eg countries were given only 6 weeks to submit their first Round proposals.[5]
- the introduction of new ways of doing business at country level: making aid performance-related; expecting countries to apply for aid and making them accountable for its use; broadening levels of participation in the application and delivery process; and monitoring and evaluating performance and progress. These have required new roles and relationships between traditional players at country level.
- a tracking study of four African countries (Mozambique, Tanzania, Uganda and Zambia) found that governments and NGOs were most positive about the Global Fund, citing as benefits the new funding and the autonomy of a country-led process. Country representatives of bilateral donors supporting SWAps were often sceptical, suggesting that it was reverticalising health systems and forcing a diseases-specific approach.[6] There was some suggestion that bilateral donors

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[1] US General Accounting Office**,** GFATM has Advanced in Key Areas but Difficult Challenges Remain,GAO-03-601, May 2003
[2] Ibid
[3] Radelet S, *The Global Fund to Fight AIDS, TB, and Malaria: Progress, Potential, and Challenges for the Future, Center for Global Development*, June 2004
[4] Radelet S, *The Global Fund to Fight AIDS, TB, and Malaria: Progress, Potential, and Challenges for the Future, Center for Global Development*, June 2004
[5] UNAIDS. *UNAIDS Support for Countries Accessing the Global Fund. HIV/AIDS Proposals: Lessons from Round One* August 2002; Grace C., *Global Fund Country Case Studies Report*. London: DFID Health Systems Resource Centre, January 2003.
[6] Brugha R et al, www.thelancet.com Vol 364 July 3, 2004

have felt marginalized.[7] However, another early study suggested that aspects of GFATM operations were designed to ensure a good fit between the disease-specific focus and the broader health care system[8].

- the GF's willingness to learn and respond flexibly to country concerns.[9]
- indications of saving lives and other tangible progress in combating HIV/AIDS, TB and malaria.

Concerns and challenges

The many studies, mostly qualitative reporting country-level views, explore a range of concerns and challenges. The most important include:

- the financial sustainability of the GFATM, and the specific consequences for ARV and ACT treatment programs of interrupted support.[10]
- disbursement delays, particularly compared with original expectations[11]. One factor was the need to establish new and untested systems for disbursing funds.
- lack of harmonisation and alignment with national processes and other donors, even where strong systems already exist. There has been widespread concern about the establishment of parallel processes[12]. One general study noted that, in most countries, either the Fund has very few (if any) partners to coordinate with, or existing reporting and monitoring systems are weak[13]. The LSHTM tracking study of four SWAp countries found that government and donor representatives emphasised the importance of the GFATM supporting coordinated national strategies, but noted growing flexibility on the part of the Fund[14].
- burdensome procedures, and a strong sense of the goalposts having been changed over time with some retrospective requirements. Studies suggest that the GF should minimise the burden of its reporting requirements in particular. For example, annual or biannual assessments of performance should replace quarterly reports as a basis for decisions on disbursement. Excessive reporting will be beyond the capacity of countries with weak systems which have greatest need of additional funds[15].
- inadequate attention to country context and health systems issues in the technical evaluation by the GFATM Technical Review Panel. An early study also recommended that increased focus should be given to issues of equity in the evaluation process[16].
- some aspects of GF-specific architecture, especially the evolution over time of CCMs and LFAs, with some continuing confusion. These are crucial bodies given the GF's decision not to have local staff. One study[17] suggested that a national or

[7] Brugha R et al, Tracking the Global Fund in Four Countries: an interim report - Mozambique, Tanzania, Uganda, Zambia, London School of Hygiene and Tropical Medicine, October 2003. Plus draft discussion paper 18 December 2004, and individual case studies in the four countries.
[8] Bennett S. and Fairbank A., *The System Wide Effects of The Global Fund: A Conceptual Framework,* Partners for Health Reform Plus - ABT Associates, October 2003
[9] Radelet S, The Global Fund to Fight AIDS, TB, and Malaria: Progress, Potential, and Challenges for the Future, Center for Global Development, June 2004,; LSHTM tracking studies cited above.
[10] GFATM Board papers; Radelet S, *The Global Fund to Fight AIDS, TB, and Malaria: Progress, Potential, and Challenges for the Future, Center for Global Development*, June 2004
[11] Brugha R et al, www.thelancet.com Vol 364 July 3, 2004.
[12] In many reports, including: UNAIDS, *UNAIDS Support for Countries Accessing the Global Fund. HIV/AIDS Proposals: Lessons from Round One* August 2002; Grace C., *Global Fund Country Case Studies Report*. London: DFID Health Systems Resource Centre, January 2003, and the Brugha et al GFATM tracking studies, LSHTM
[13] Radelet S, *The Global Fund to Fight AIDS, TB, and Malaria: Progress, Potential, and Challenges for the Future, Center for Global Development*, June 2004
[14] Brugha R et al, www.thelancet.com Vol 364 July 3, 2004
[15] Brugha R et al, www.thelancet.com Vol 364 July 3, 2004
[16] Grace C., *Global Fund Country Case Studies Report*. London: DFID Health Systems Resource Centre, January 2003
[17] Kruse S. and Claussen J., *Review of the Roles, Functions and Performance of Local Fund Agents*, August 2004

regional GF representative – perhaps hosted by a multilateral agency – would not be likely to exceed the cost of the current LFA system.

- CCMs, which have been studied extensively. They are working well in some countries but not in many others[18]. Rapid rolling-out of new structures without adequate and timely guidelines on CCM roles and operations led to confusion among some CCM members[19]. Studies noted concerns about legitimacy, especially in comparison to National AIDS Councils; size, representation and appropriate skills for the task; government dominance; the uneasy fit of CCMs with National AIDS Councils. CCMs have been involved in proposal preparation, though in some cases nominally. But an immediate concern is that CCMs are not seen as well-placed or equipped to carry out their role in overseeing implementation[20].
- LFAs. The cost of LFAs amounted to 31% of Global Fund operating costs in 2003 and an estimated 42% in 2004, where overall GF operational expenditure is judged to be *low* compared with total funds committed. The continuing growth in GF activity will increase future reliance on LFAs in project appraisal and monitoring. There are concerns about LFAs' weakness in some technical expertise (eg in procurement and health monitoring and evaluation). So far most performance has been assessed on relatively simple indicators, but LFAs will need to assess more complex programme indicators as implementation gets fully underway[21].
- a critical lack of an institutional mechanism to link assessments with technical advice and remedial action. "Most LFAs do not share reports with CCMs and PRs, and the Global Fund were not found to release the assessments. In practice, they were not available to technical partners" who could support countries[22].
- this echoes wider complaints of weak communications between most sets of players involved[23].
- operating on performance-based principles. There remain important technical questions about how best to set up a robust performance-based system that judges performance fairly and provides appropriate incentives[24]. It is also not clear how the Board will react when countries achieve sub-par performance. This is an immediate issue given the current review of Phase 1 performance on the first 27 grants.
- the increasing complexity of the HIV/AIDS aid environment at country level (especially in relation to MAP and PEPFAR). This has created problems of coordination and capacity shortfalls[25].

[18] Radelet S, *The Global Fund to Fight AIDS, TB, and Malaria: Progress, Potential, and Challenges for the Future, Center for Global Development*, June 2004
[19] Brugha R et al, www.thelancet.com Vol 364 July 3, 2004
[20] Many studies including 20 country case studies initiated by the GFATM itself; Grace C., *Global Fund Country Case Studies Report*. London: DFID Health Systems Resource Centre, January 2003; the various reports from the LSHTM tracking study cited above; UNAIDS. *UNAIDS Support for Countries Accessing the Global Fund. HIV/AIDS Proposals: Lessons from Round One* August 2002; and other studies.
[21] Kruse S. and Claussen J., *Review of the Roles, Functions and Performance of Local Fund Agents*, August 2004
[22] Kruse S. and Claussen J., *Review of the Roles, Functions and Performance of Local Fund Agents*, August 2004
[23] For example, in Grace C., *Global Fund Country Case Studies Report*. London: DFID Health Systems Resource Centre, January 2003
[24] Radelet S, *The Global Fund to Fight AIDS, TB, and Malaria: Progress, Potential, and Challenges for the Future*, Center for Global Development, June 2004.
[25] Brugha R et al, www.thelancet.com Vol 364 July 3, 2004.

ANNEX 11: List of GFATM Studies

TITLE	AUTHOR/LED BY	DATE
GENERAL/EVALUATION		
The Global Fund to Fight AIDS, TB, and Malaria: Progress, Potential, and Challenges for the Future	Steve Radelet, Center for Global Development	June 2004
Global Fund Has Advanced in Key Areas, but Difficult Challenges Remain	United States GAO	May 2003
The System Wide Effects of The Global Fund: A Conceptual Framework	Sara Bennett and Alan Fairbank, Partners for Health Reform Plus - ABT Associates	October 2003
Common Research Protocol. Monitoring and Evaluating the Health System Wide Effects of the Global Fund	System Wide Effects of the Fund Research Network	November 2003
Inventory of M&E Practices and Systems for Global Health Organizations	SIDA	February 2004
Monitoring and Evaluation Toolkit: HIV/AIDS, TB and Malaria	GFATM	June 2004
Measurement Framework for the Global Fund's purpose and core principles: Focus on additionality, partnerships and sustainability	William McGreevey, Veronica Walford and Stein-Erik Kruse	*DRAFT*
UNAIDS Support for Countries Accessing the Global Fund. HIV/AIDS Proposals: Lessons from Round One	UNAIDS	August 2002
Global Fund Country Case Studies Report	Cheri Grace, DFID Health Systems Resource Centre	January 2003
Assessing the Impact of Global Health Partnerships: synthesis report and individual studies	DFID	January 2005
Country Case Studies: The Early Steps of the Global Fund in Cambodia	Directorate General Development Corporation, Belgium and the Institute of Tropical Medicine	December 2003
Tracking the Global Fund in Four Countries: an interim report - Mozambique, Tanzania, Uganda, Zambia Plus draft discussion paper 18 December 2004	Brugha R, Walt G, Starling M, Donoghue M London School of Hygiene and Tropical Medicine (LSHTM)	October 2003
GFATM Tracking Study - Tanzania	LSHTM	January 2004
GFATM Tracking Study - Uganda	LSHTM	January 2003
GFATM Tracking Study - Zambia	LSHTM	January 2004
GFATM Tracking Study - Mozambique	LSHTM	May 2004

TITLE	AUTHOR/LED BY	DATE
CCMs		
CCM and the Broader Country Level Co-ordination Context. With special reference to HIV/AIDS	UNAIDS	January 2003
A Multi-Country Study of the Involvement of PLWHA in the CCMs	Global Network of PLWHA (GNP+)	October 2003
CCM Case Studies - 20 countries	Independent Consultants and GTZ, Italian Bilateral Cooperation, French Ministry of Health	November 2003 through April 2004
CCMs: A Synthesis and Analysis of findings from CCM Case Studies, Tracking Study, GNP+ and Other Surveys	GFATM Governance and Partnership Committee and Secretariat	April 2004
CCMs: Building Good Governance	GFATM Secretariat	June 2004
CCMs: Analysis of CCM composition for Round 3	GFATM Secretariat	October 2003
CCMs: Analysis of CCM composition for Round 4	GFATM Secretariat	June 2004
Multilateral and Bilateral Participation in CCMs - Round 4	GFATM Secretariat	June 2004
The CCM-Forum of the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM): towards transparency through information sharing'	GFATM Independent Consultant	June 2004
Review of the Roles, Functions and Performance of Local Fund Agents	Stein-Erik Kruse and Jens Claussen	August 2004
NGOs/Private sector		
NGO Participation in the Global Fund	International HIV/AIDS Alliance	October 2002
Global Fund Responsiveness to Faith Based Organizations	Christian Connections for International Health and Ecumenical Pharmaceutical Network	January 2003
Faith-Based Organizations: Contributions to HIV Prevention	Harvard Center for Population and Development Studies	September 2002
Civil Society Participation in Global Fund Governance: What Difference Does it Make? Preliminary research findings	International Center for Research on Women	June 2004
Private Sector Solutions to Global Public Challenges in Health Opportunities for Collaboration. Conference	McKinsey & Co.	June 2003